

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/08/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>10/08/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SMITH CENTER HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 W 1ST ST #369 SMITH CENTER, KS 66967</b>		
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F 000	INITIAL COMMENTS	F 000			
F 274 SS=D	<p>The following citations represent the findings of complaint investigations #91292 and #91413.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This Requirement is not met as evidenced by: The facility had a census of 27 residents. The sample included 3 residents reviewed for accidents. Based on observation, record review and interview the facility failed to complete a significant change (MDS) Minimum Data Set assessment for 1 of 3 residents. Resident #1 returned from the hospital, after a fall which resulted in a fractured hip.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #1's 5 day Medicare (MDS) Minimum Data Set assessment, dated 9/15/15, indicated the resident usually understood/usually understands others, scored 6 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment, and inattention</li> </ul>	F 274			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	<p>Continued From page 1</p> <p>which was continuous. The MDS indicated the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting, and extensive assistance of 1 staff for walk in room/corridor, locomotion on/off unit, grooming, and bathing. The MDS indicated the resident had 1 fall without injury and 1 fall with major injury, (fractured hip), since prior assessment completed. The 14 day MDS, dated 9/22/15, unchanged except for a BIMS score of 7, inattention which fluctuated, and the resident required extensive assistance of 1 staff for bed mobility, transfers, toileting, grooming, walk in room/corridor, locomotion on/off unit. The MDS indicated the resident had 1 fall without injury since completion of the last assessment.</p> <p>The 7/7/15 quarterly MDS indicated the resident was usually understood/usually understands others, had a BIMS score of 12, which indicated moderate cognitive impairment, and required extensive assistance of 1 staff for toileting, and supervision with set up help only for bed mobility, transfers, walk in room/ corridor, locomotion on/off unit, and grooming.</p> <p>Review of the resident's MDS assessments dated 9/15/15 and 9/22/15, indicated the resident required extensive assistance of 1-2 staff for most (ADLs) Activities of Daily Living, compared to supervision with set up help only on the quarterly MDS dated 7/7/15.</p> <p>Further review of the resident's medical record revealed staff did not complete a significant change MDS, after the resident returned from the hospital.</p> <p>On 10/5/15 at 7:56 AM, observation revealed the well groomed resident, seated in the wheelchair,</p>	F 274			

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F 274	<p>Continued From page 2</p> <p>at the breakfast table, eating breakfast. Observation revealed the resident receiving oxygen per concentrator, and a personal and chair alarm in place.</p> <p>On 10/5/15 at 5:50 PM, Administrative Nurse A stated he/she should have completed a significant change MDS on the resident's return to the facility due to the fractured hip and needing more staff assistance with ADLs.</p> <p>On 10/6/15 at 8:12 AM Administrative Nurse B verified staff should have completed a significant change MDS on the resident when he/she returned from the hospital after the hip fracture and needing more assistance with ADLs.</p> <p>The 2001 facility policy for MDS Error Correction indicated a significant change MDS should be completed due to major changes in the resident's status.</p> <p>The facility failed to complete a significant change MDS after Resident #1 returned from the hospital with a fractured hip, resulting from a fall, and required more staff assistance with his/her ADLs.</p>	F 274			
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>	F 279			

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F 279	<p>Continued From page 3</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This Requirement is not met as evidenced by: The facility had a census of 27 residents. The sample included 3 residents reviewed for falls and incontinence. Based on observation, record review and interview the facility failed to develop a comprehensive care plan for 1 of 3 residents for toileting.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #1's 14 day Medicare (MDS) Minimum Data Set assessment, dated 9/22/15, indicated the resident usually understood/understands others, and scored 7 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment. The resident had inattention which fluctuated, and required extensive assistance of 1 staff for bed mobility, transfers, toileting, grooming, walk in room/corridor, and locomotion on/off unit. The MDS indicated the resident occasionally incontinent of bladder, no toileting program and received diuretics.</li> </ul> <p>Review of the resident's medical record revealed no incontinence or toileting program in place for the incontinent resident.</p> <p>Review of the resident's medical record revealed</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>the resident did not have an initial toileting care plan.</p> <p>The 10/1/15, bladder incontinence evaluation indicated the resident wears incontinent briefs at all times and received a daily diuretic. The evaluation indicated the resident had impaired cognitive function, and needed physical assistance to access the toilet with staff providing stand by assistance due to decreased muscle strength affecting his/her lower extremity. The evaluation revealed no direction to staff on care of the incontinent resident.</p> <p>On 10/5/15 at 8:57 AM, observation revealed Nurse Aide C propelled the resident from the dining room to his/her room, then used a gait belt and ambulated the resident with his/her walker to the toilet. Nurse Aide C stated the resident's incontinent brief needed to be changed as it had not been changed when the staff dressed the resident this morning.</p> <p>On 10/1/15 at 1:30 PM, Nurse Aide D stated the resident was incontinent of urine at times.</p> <p>On 10/6/15 at 7:20 AM, Nurse E stated the resident was continent of urine most of the time but would attempt to take him/herself to the bathroom because he/she forgets to use the call light to ask for assistance.</p> <p>On 10/6/15 at 8:12 AM, Administrative Nurse B verified the resident did not have a toileting care plan. Administrative Nurse also stated the nurses do a nursing quarterly evaluation including urinary incontinent review which included if the resident was incontinent or not and any symptoms of (UTI) Urinary Tract Infection. Administrative Nurse B verified Resident #1 did not have an</p>	F 279			

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F 279	Continued From page 5 individualized toileting program.  The 2011 facility behavioral programs and toileting plans for urinary incontinence policy indicated the staff were to monitor, record and evaluate information about the resident's bladder habits, and continence or incontinence including voiding patterns, level of incontinence and response to specific interventions. The policy indicated the staff were to record the resident's current voiding pattern including voiding times and amount.  The facility failed to develop an individualized toileting care plan for Resident #1, who was incontinent of urine.	F 279			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This Requirement is not met as evidenced by: The facility had a census of 27 residents. The sample included 3 residents reviewed for incontinence. Based on observation, record review and interview the facility failed to monitor and assess the resident's toileting routine to develop individualized toileting programs for 3 of 3 sampled residents. (#1, #2, #3)	F 315			

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F 315	<p>Continued From page 6</p> <p>Findings included:</p> <p>- Resident #1's 14 day Medicare MDS, dated 9/22/15, indicated the resident usually understood/usually understands others, scored 7 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment, inattention which fluctuated, and required extensive assistance of 1 for bed mobility, transfers, toileting, grooming, walk in room/corridor, and locomotion on/off unit. The MDS indicated the resident occasionally incontinent of bladder, no toileting program and received a diuretic.</p> <p>Review of the resident's medical record revealed the resident did not have an initial toileting care plan.</p> <p>Review of the resident's medical record revealed a 3 day toileting pattern had not been completed since he/she was admitted to the facility.</p> <p>The bladder incontinence evaluation, dated 10/1/15, indicated the resident wears incontinent briefs at all times and received a daily diuretic. The evaluation indicated the resident had impaired cognitive function, and required staff stand by assistance to toilet due to decreased muscle strength affecting his/her lower extremity.</p> <p>On 10/5/15 at 8:57 AM, observation revealed Nurse Aide C propelled the resident from the dining room to his/her room, used a gait belt and ambulated the resident with his/her walker to the toilet. Nurse Aide C stated the resident's incontinent brief needed to be changed as it had not been changed when the staff dressed the resident this morning.</p>	F 315			

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F 315	<p>Continued From page 7</p> <p>On 10/1/15 at 1:30 PM, Nurse Aide D stated the resident was incontinent of urine at times.</p> <p>On 10/5/15 at 3:20 PM, Administrative Nurse B stated the resident was continent on admission so the nurses did not complete a 3 day toileting tool. Administrative Nurse B stated it was facility policy to complete a 3 day toileting plan on all resident's upon admission and annually.</p> <p>On 10/6/15 at 7:20 AM, Nurse E stated the resident was continent of urine most of the time but would take him/herself to the bathroom as he/she forgets to use the call light to ask for assistance to.</p> <p>On 10/6/15 at 8:12 AM, Administrative Nurse B verified the resident did not have a toileting care plan. Administrative Nurse B also stated the nurses do a quarterly evaluation including urinary incontinent review which included if the resident was incontinent or not and any symptoms of (UTI) Urinary Tract Infection. Administrative Nurse B verified Resident #1 did not have an individualized toileting program.</p> <p>The 2011 facility's behavioral programs and toileting plans for urinary incontinence policy, indicated staff were to monitor, record and evaluate information about the resident's bladder habits, continence or incontinence, including voiding patterns, level of incontinence, and response to specific interventions. The policy indicated staff were to record the resident's current voiding pattern including voiding times and amount.</p> <p>The facility failed to assess Resident #1 for a change in bladder function, after admission, to determine if there was a change in urinary</p>	F 315			

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F 315	<p>Continued From page 8</p> <p>continence and develop an individualized toileting program.</p> <p>- Resident #2's quarterly (MDS) Minimum Data Set assessment, dated 8/2/15, indicated the resident usually understood/usually understands others, scored 7 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment, inattention continuously, and other behaviors not directed towards others, occurred 1-3 days during the lookback period. The MDS indicated the resident required total dependence on 2 staff for bed mobility, transfers, toileting and bathing, total dependence on 1 staff for dressing, extensive assistance of 2 staff for walk in room, and extensive assistance of 1 for locomotion on/off unit, and grooming. The MDS indicated the resident had a current toileting program and frequently incontinent of urine.</p> <p>The 8/20/15 care plan instructed staff to toilet the resident every 2-3 hours and as needed.</p> <p>Review of the resident's medical record revealed staff had completed a 3 day voiding diary, 2/3/25-2/5/15, with documentation the resident was incontinent of urine during all three shifts on all 3 days.</p> <p>Further review of the resident's medical record revealed staff had not completed a 3 day toileting pattern since admission (on 4/1/15).</p> <p>The 8/2/15 bladder incontinence evaluation indicated the resident voided frequently with no routine times and required extensive assistance of 1 staff for toileting needs. The evaluation indicated the resident had functional incontinence and multiple attempts with toileting programs had</p>	F 315			

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F 315	<p>Continued From page 9 not been successful.</p> <p>On 10/1/15 at 1:10 PM, observation revealed the well groomed resident, seated in his/her recliner, watching television.</p> <p>On 10/1/15 at 2:40 PM, Nurse Aide C stated the staff toileted the resident every 2-3 hours, and before/after meals, as the resident could not tell staff if he/she needed to use the toilet.</p> <p>On 10/6/15 at 7:20 AM, Nurse E stated the resident was mostly continent but did not use his/her call light to ask for assistance to the bathroom and the aides offer to take him/her every 2 hours.</p> <p>On 10/6/15 at 8:30 AM, Administrative Nurse B stated the nurses do a quarterly evaluation including urinary incontinence review which includes if the resident was incontinent or not, any symptoms of (UTI) Urinary Tract Infection, but did not do a 3 day voiding pattern except on admission and annually. Administrative Nurse B verified the resident did not have an individualized toileting program.</p> <p>The 2011 facility's behavioral programs and toileting plans for urinary incontinence policy, indicated the staff were to monitor, record and evaluate information about the resident's bladder habits, continence or incontinence, including voiding patterns, level of incontinence, and response to specific interventions. The policy indicated the staff were to record the resident's current voiding pattern including voiding times and amount.</p> <p>The facility failed to assess Resident #2 for change in bladder function, after admission, to</p>	F 315			

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F 315	<p>Continued From page 10</p> <p>determine if there was a change in urinary continence and develop an individualized toileting program.</p> <p>- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 9/4/15, indicated the resident had unclear speech, sometimes understands, with short term memory loss, and moderately impaired daily decision making. The MDS indicated the resident displayed disorganized thinking which fluctuated, and required extensive assistance of 2 staff for bed mobility, transfers, toileting, and extensive assistance of 1 staff for locomotion on/off unit, dressing, grooming and bathing. The MDS indicated the resident occasionally incontinent of urine.</p> <p>The 5/20/15 (CAA) Care Area Assessment for urinary incontinence indicated, due to a stroke, the resident required staff assistance to the bath room. The CAA indicated, according to the 3 day voiding diary, the resident was continent of urine but was at risk for urinary incontinence due to poor mobility.</p> <p>The 8/3/15 care plan for (ADL) Activities of Daily Living self care performance deficit related to post stroke with right side hemiparesis (muscular weakness of one half of the body), and instructed 1-2 staff to provide assistance with toileting needs.</p> <p>The 8/2/15 bladder incontinence evaluation indicated the resident wore adult briefs at all times and voided 2-3 times during 6a-2p, 2-3 times 2p-10p and usually 1 time during 10p-6a. The evaluation indicated the resident had impaired cognitive function, decreased manual</p>	F 315			

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NAME OF PROVIDER OR SUPPLIER  <b>SMITH CENTER HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 W 1ST ST #369 SMITH CENTER, KS 66967</b>		
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F 315	<p>Continued From page 11</p> <p>dexterity (use of hand or body skills), and required physical assistance to access the toilet, with decreased muscle strength affecting his/her upper extremity. The evaluation indicated the resident had functional incontinence with staff providing prompted voiding and incontinent products/garments.</p> <p>The 3 day voiding pattern, dated 5/9/15-5/11/15, indicated the resident was incontinent of urine only at 6 am on 5/9/15.</p> <p>Review of the resident's medical record revealed staff had not completed another 3 day voiding pattern.</p> <p>On 10/5/15 at 7:56 AM, observation revealed the well groomed resident, seated in his/her wheelchair at the breakfast table, eating breakfast.</p> <p>On 10/1/15 at 1:30 PM, Nurse Aide D stated the resident was usually continent of urine and did not always call for assistance to go to the toilet.</p> <p>On 10/6/15 at 7:20 AM, Nurse E stated the resident was usually continent of urine and did not always uses his/her call light to ask for assistance to the toilet and would try to take him/herself.</p> <p>On 10/6/15 at 8:30 AM, Administrative Nurse B stated the nurses do a quarterly evaluation including urinary incontinence review which includes if the resident was incontinent or not, any symptoms of (UTI) Urinary Tract Infection, but did not do a 3 day voiding pattern except on admission and annually. Administrative Nurse B verified the resident did not have an individualized toileting program.</p>	F 315			

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F 315	Continued From page 12  The 2011 facility's Behavioral programs and Toileting Plans for urinary incontinence policy, indicated staff were to monitor, record and evaluate information about the resident's bladder habits, continence or incontinence including voiding patterns, level of incontinence, and response to specific interventions. The policy indicated staff were to record the resident's current voiding pattern including voiding times and amount.  The facility failed to assess Resident #3 for change in bladder function, after admission, to determine if there was a change in urinary continence and develop an individualized toileting program.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This Requirement is not met as evidenced by: The facility had a census of 27 residents. The sample included 3 residents reviewed for falls. Based on observation, record review and interview the facility failed to ensure 1 of 3 residents received adequate supervision to prevent accidents. (#1)  Findings included:  - Resident #1's 5 day (MDS) Minimum Data Set	F 323			

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F 323	<p>Continued From page 13</p> <p>assessment, dated 9/15/15, indicated the resident usually understood/usually understands others, scored 6 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment and had continuous inattention. The MDS indicated the resident required extensive assistance of 2 staff for bed mobility, transfers, toileting, and extensive assistance of 1 staff for walk in room/corridor, locomotion on/off unit, grooming, and bathing. The MDS indicated the resident occasionally incontinent of urine and had 1 fall without injury, 1 fall with major injury, and a fractured hip, since the prior assessment.</p> <p>The 4/8/15 (CAA) Care Area Assessment indicated on 3/13/15, prior to admission to the facility, the resident fell downstairs in his/her apartment complex laundry room while looking for the bathroom.</p> <p>The 9/17/15 care plan informed the staff the resident could not remember to use his/her call light for assistance before getting up, staff replaced the current bed with a low bed, and directed staff to implement a chair/alarm. The care plan instructed the staff to give the resident verbal reminders not to ambulate/transfer without assistance when not feeling well or having pain. (the staff assessed the resident had severe cognitive impairment and required extensive staff assistance to walk). The care plan instructed the staff to ensure the resident had proper, well maintained footwear, and used a walker when ambulating with staff. The care plan revealed no documentation the resident was occasionally incontinent and no direction to staff for toileting the dependent resident.</p> <p>Review of the resident's medical record revealed no incontinence or toileting program in place for</p>	F 323			

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F 323	<p>Continued From page 14 the incontinent resident.</p> <p>The 7/3/15 fall risk assessment indicated the resident was at low risk.</p> <p>The 9/4/15 at 11:45 AM, fall notes indicated the resident reported to the nurse aide he/she fell in his/her room and got him/herself back up. The note indicated the resident was sitting in his/her recliner and verbalized pain in his/her left leg/hip area when he/she stood up, to get ready for the noon meal. The note did not indicate if the resident was continent or incontinent. The note indicated the resident transferred to the emergency room, by (EMS) Emergency Medical Service, as directed by the physician.</p> <p>The 9/4/15 left hip and pelvis x-ray indicated the resident had a femoral neck fracture and severe arthritis of the left hip.</p> <p>The 9/11/15 physician's order (initiated 6/25/15) instructed the staff to administer HCTZ (a diuretic medication), 25 (mg) milligrams, 1/2 tablet daily in AM.</p> <p>The 9/29/15 at 7:45 PM, nurse's notes indicated the resident had very poor short and long term memory and did not remember instructions most of the time. The note indicated the resident had a bed/chair alarm to alert staff if the resident got up independently because he/she didn't remember to call for staff assistance all of the time (although the current care plan did not indicate staff implemented a bed alarm). The note indicated the resident had a steady gait most of the time but forgot to use the walker and the correct technique for ambulating with the walker, if staff were not with him/her.</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>The 9/30/15 at 9:15 AM, fall notes indicated the staff heard a noise in the resident's room and the resident's chair alarm was sounding. The staff found the resident sitting in front of his/her recliner. Observation revealed the recliner tipped over forward with the foot rest in the up position. The noted indicated the resident had no pain/discomfort or injuries from the fall. The notes did not indicate if the resident was continent or incontinent.</p> <p>The 10/3/15 at 3:14 PM, fall notes indicated the resident continued to be unsafe getting up without calling for staff assistance to assist him/her in his/her room. The note further stated the pressure alarms were in place and alerted the staff to him/her getting up and the staff had been able to reach the resident at the time, without further incident.</p> <p>On 10/5/15 at 8:57 AM, observation revealed the resident seated in a wheelchair propelled by Nurse Aide C from the dining room to his/her room. Nurse Aide C used a gait belt and ambulated the resident with his/her walker to the toilet. Nurse Aide C stated the resident's incontinent brief needed to be changed as it had not been changed when the staff dressed the resident this morning, but was not wet.</p> <p>On 10/1/15 at 11:15 AM, Nurse F stated the resident had a fall which resulted in a hip fracture and stated the resident does not remember to use his/her call light to ask for staff assistance.</p> <p>On 10/6/15 at 7:20 AM, Nurse E stated the resident was continent of urine most of the time but would attempt to take him/herself to the bathroom because he/she forgets to use the call light to ask for assistance.</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>The 10/1/15 bladder incontinence evaluation indicated the resident wears incontinent briefs at all times and received a daily diuretic (fluid eliminating medication). The evaluation indicated the resident had impaired cognitive function, and needed physical assistance to access the toilet, with staff providing stand by assistance, due to decreased muscle strength affecting his/her lower extremity. The evaluation revealed no direction to staff on the toileting needs of the incontinent resident.</p> <p>Review of the resident's medical record revealed no incontinence or toileting program in place for the incontinent resident who received a diuretic.</p> <p>On 10/5/15 at 3:20 PM, Administrative Nurse B stated the resident leans over when sitting in the recliner and loses his/her balance and has fallen out of the recliner. Administrative Nurse B verified the resident fell in September and fractured his/her left hip. Administrative Nurse B stated before the resident's fall resulting in left hip fracture, the resident did most of his/her own (ADLs) Activities of Daily Living and refused staff assistance most of the time.</p> <p>On 10/8/15 at 9:04 AM, Administrative Nurse B stated the nurses had reviewed the resident's current medications but did not document the review. Administrative Nurse B stated the resident was not incontinent of urine at the time of her falls, as far as he/she knew.</p> <p>The 2/2014 facility's fall and fall risk managing policy, stated if the resident continued to fall, the staff would re-evaluate the situation and whether it was appropriate to continue current interventions. The policy indicated the attending</p>	F 323			

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F 323	Continued From page 17 physician would help the staff reconsider possible causes that may not previously have been identified.  The facility failed to provide supervision to prevent falls for Resident #1, who had a history of falls.	F 323			